A Patient’s story

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Abstract

A patient’s perceptions of the care he received will be discussed. The patient was very satisfied with the physical and functional outcomes of his surgery but highlighted many areas of concern regarding his psychological care. He provided examples of ‘poor’ care which he received from the whole health care team.

This is not intended to be a ‘shock and awe’ story but rather an opportunity to ‘pause and think’ about this patient’s care and the lessons which can be learnt from it (Carter 2007). Alongside this, the value of using a patient’s story is discussed.

Recommendations for future practice will be made.

Key words: Quality care, Patient’s story, Patient’s narrative, Holistic care.

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A Patient’s Story- opportunity or threat?

Patient’s stories or narratives are not a new concept. Indeed they have been used for a long time in health care practice. The terms ‘patient’s stories’ and ‘patient’s narratives’ are often used interchangeably. The importance of obtaining the opinions of patients has long been recognised and traditionally, most contact has been focused on measuring their satisfaction with the services they receive (Wilcock et al 2003). The strategy used for gaining the patient’s view has often been via a patient satisfaction survey. However the limitations of these are well known and documented (McIver 1993). Most importantly, patient satisfaction data may in fact differ from the patient’s actual experience. Using a patient’s story or narrative may offer possibilities as a powerful way to improve care. Patient narratives can develop understanding that is grounded in experience and can stimulate reflection that leads to the generation of new ideas (Greenhalgh & Hurwitz 1998). Moreover it is crucial to remember that the quality of care can only be measured by patients themselves (Goossen 2002). Alongside this the patient’s voice is becoming increasingly important in shaping healthcare systems (DH 2007a; DH 2007b; Davis 2007). Indeed the ‘Creating a Patient-Led NHS’ white paper (DH 2006) called for NHS organisations to use new and different methodologies to better understand patients. Without doubt, patients themselves are the best sources of information for assessing the quality of care (Sorlie et al 2006).

During the course of a nurse-led clinic, an elderly gentleman who will be referred to as a pseudonym, ‘Michael’ presented for a routine, six week follow-up appointment. He had been in hospital for a week following a total hip replacement. At the beginning of the consultation Michael was keen to discuss the care he received whilst in hospital. Interestingly, this aspect of care is not usually discussed at this stage. He was concerned at the quality of care he received particularly in relation to privacy, dignity and confidentiality. Indeed he was pleased with the
Michael’s story

Michael was admitted and ‘clerked in’ by a junior doctor who was drinking a can of cola at the time. This first impression did little to assuage his pre-operative anxiety level. Interestingly Lees (2005) highlights that medical staff do not routinely receive education or training in some aspects of history taking. However, patients expect professional care from competent staff (Job 2005; Sorlie 2006; DH 2008).

Michael was called by names that were unacceptable to him e.g. “Mickey” when he has always been known as Michael. This did not convey respect and indeed highlights that the health care professional did not really know the patient well. Knowing the patient has been identified as important in providing quality care (Luker et al 2000; Clarke et al 2003). Redfern & Norman (1999) identify attitudes, sensitivity and a philosophy of individualised care as indicators of high quality care for older people.

When other patients asked him where he lived, Michael gave a different locality instead of his correct address. He was concerned because his house was unoccupied and could be at risk of burglary. Unfortunately a ‘nurse’ overheard this conversation and quickly corrected Michael. This ‘nurse’ inadvertently breached patient confidentiality by disclosing Michael’s address. Michael felt his privacy was infringed upon as well as confidential information had been breached by staff he expected to be able to trust. Michael had a legitimate expectation that staff will respect his privacy (DH 2003; NMC 2008; Matiti & Trorey 2008). Furthermore, the duty of confidentiality arises out of the common law of confidentiality, professional obligations, and also staff employment contracts (DH 2003). Breach of confidence can lead to disciplinary measures and indeed bring into question professional registration.

This is not intended to be a ‘shock and awe’ story, but rather a ‘pause and think’ opportunity (Carter 2007). Michael discussed these issues six weeks after he had been discharged from hospital. He did not raise these concerns as an inpatient. It has been acknowledged that patients may not become involved in reporting care because it might affect their treatment in the future (Modernisation Agency 2005). Michael did not feel he could complain whilst he was an inpatient as he believed it would affect his care. Sorlie et al (2006) warns that although many patients state that they are satisfied with their care there are also factors that patients do not consider as optimal. Often the patients make compromises that must be accepted as a necessary part of their stay in the ward.

Clearly patients are not one, homogenous group, but rather individuals who have different ages, sex and experiences in life (Sorlie et al 2006). Murphy (2007) purports that while many staff perceive the need for care to be holistic, the physical aspects of care are given priority and valued most highly in practice. Priest (2006) purports that there is considerable evidence to suggest that nurses often inadequately identify and respond to patient’s psychological needs. This can lead to adverse consequences for patient’s physical health and recovery. Davis (2007) concurs that there is a need to listen more attentively to patients. Moreover, he suggests that health professionals can be arrogant in their relationship with patients and that it is important to remember that the health care professionals’ knowledge base and understanding may be different to patients but is no better or worse. Henderson (2003) agrees that there is an imbalance in power between nurses and patients and patients are vulnerable.
The National Service Framework for Older People (DH 2001), the Essence of Care (DH 2003) and The Code (NMC 2008) contain clear standards for patient care in hospital and focus on improving the experiences of care. In addition one of the benchmarks from the Essence of Care directly relates to privacy and dignity. Staff need to recognise and value the importance of their contribution to the fundamental and essential aspects of care.

Alongside this it has been recognised some time ago that the ethos of the ward environment has the potential to influence the delivery of quality care. This ethos may be shaped positively by having a philosophy of care that guides practice (Redfern & Norman 1999) and good ward leadership (Kitson 1991; Nazarko 1998, Bravo et al 1999). Indeed the ward philosophy should be developed by all staff on the ward and reviewed regularly. There has been a high focus on achieving government targets, such as the 18 week wait, which clearly has impacted on the workload of all clinical staff. However it is now evident that the focus must change from quantity to quality of care (DH 2008).

In the UK the Health Service Ombudsman (2003) regularly receives complaints about lack of attention to psychological needs. Poor communication between staff and patients and inaccurate perceptions of patients’ emotional needs continue to be identified as important practice issues (King 2003; Nyden et al 2003). It appears that the multi-professional team need to be educated about the concept of psychological care. Alongside this, staff need to receive feedback from the patient’s perspective about their experience. Moreover, patients require a forum where they can raise concerns and feel safe doing so. Further discussion about where and when this could take place is needed. Information relating to the patients’ experiences of secondary care could be captured in routine follow-up clinics. Qualitative methods can be used to examine patients’ experiences in more depth (Wensing & Elwyn 2003). However, it is not enough to just capture this information as action is then required to address any shortfalls. Although this may involve more resources from an already tight budget, active patient involvement can only result in better processes and outcomes of care.

Michael’s story highlights that there are significant areas for improving patients’ experiences in one acute area in secondary care. There is an urgent need to make explicit the standards for protecting patient information. Patient information must be kept private. Professional roles, attitudes and accountability need to be re-examined. Education and training for staff to support practice development is required. The possibility for research into patient’s stories or narratives needs further exploration. This research can be guided by questions generated in practice. There are opportunities for collaborative work between education and practice settings that could facilitate enhanced practice.

Patient experience data has not been routinely sought but this is changing in the light of a patient-led NHS. Indeed Lord Darzi has stated that all health care providers will be required to produce ‘Quality Accounts’ which will include patients’ own views on the quality of their experience (DH 2008). Patients’ narratives may become popular methods of capturing insights into the patient experience in the future.

**Conclusion**

The perceptions of care received by an elderly gentleman being cared for in an acute ward have been discussed and analysed. Recommendations have been made to address the shortfalls discussed. Although it is important to remember that this is the experience of one gentleman, health care providers and educators need to work collaboratively to address these inadequacies. Clearly patients’ perceptions and priorities can differ from staff perceptions of care (Odell 2004). Feedback from patients therefore is vital and should be actively sought. However, it is of paramount importance that the feedback about care to staff is delivered in a sensitive, non-threatening manner in order to avoid a defensive reaction. Considering patients’ views can only improve processes and outcomes as well as patient satisfaction. Health care settings need to be open to challenges from patients as well as being constantly open to improvement. A patient’s story is an opportunity to improve care. Every patient matters!
References


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